

SF 71
Revised 3/79
OFFICE OF PERSONNEL MANAGEMENT
FPM Supply 990-2, 6 2-9

APPLICATION FOR LEAVE

71-112

INSTRUCTIONS: Please complete items 1-8 after reading the Privacy Act Statement shown below.

1. Name (Print or type—Last, First, M.I.) SEKIYA, L				2. Employee I.D. Number			
3. Organizational Unit DRMO-H/				4. Employee Signature <i>[Signature]</i>			
3. Thereby request (If more than one box is checked, explain in Item 6.)				4-A	Month	Day	Hour
FROM: <input type="checkbox"/> Annual Leave. (Annual leave requested may not exceed the amount available for use during the leave year.)				6	4	4	0730
TO: <input type="checkbox"/> Sick Leave. (Complete reverse side of form.)				6	4	4	0945
<input type="checkbox"/> Leave Without Pay. <input type="checkbox"/> Compensatory Time. <input type="checkbox"/> Other (Specify)				4-C Total Number of Hours 2.15			
6. Remarks DR APPT				8. Date Month, Day, Year 6-6-01			
<input checked="" type="checkbox"/> Approved <input type="checkbox"/> Disapproved (If disapproved, give reason. If annual leave, initiate action to reschedule.)				Signature: <i>[Signature]</i> Date: 6-6-01			

NSN 7540-00-53-5067

RAMAKRISHNA R. KOSURI, M.D.
 PARTNER ORTHOPEDIC REHABILITATION INCORPORATED
 615 PIHKOI STREET, SUITE 1210
 HONOLULU, HAWAII 96814
 PHONE: (808) 596-7300

NAME **Sekiya, Linda** AGE _____
 ADDRESS _____ DATE **06-04-01**

Rx She is under my care for chronic Rt foot pain due to plantar fasciitis. She is making progress, she needs to continue some more physical therapy sessions using night splint/heel cup.

☐ LABEL _____
 REFILL _____ TIMES

[Signature]
 DEB NO: BK 4607477 **MD**

EXHIBIT **HH**